STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055449	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covina Rehabilitation Center	261 W. Badillo Street Covina, CA 91723

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received his pain medication as ordered by the physician. This failure resulted in Resident 1 to feel mad and had the potential for Resident 1 to experience unrelieved pain. Cross Reference F755 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including respiratory failure (when the lungs cannot get enough oxygen into the blood), difficulty in walking, and dysphagia (difficulty swallowing foods or liquids). During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/1/2024, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). Resident 1 was dependent (helper does all the effort) on staff for toileting and bathing. The MDS indicated Resident 1 did not have pain in the last five days. During a review of Resident 1's untitled care plan (CP), initiated 8/5/2024, the CP indicated Resident 1 was at risk for pain and discomfort. The CP interventions included for staff to assess characteristics of pain: location, duration, quality, aggravating/alleviating factors, radiation, intensity, and notify the physician as needed and administer medication as ordered. During a review of Resident 1's Order Summary Report, dated 9/26/2024, the Order Summary Report indicated Resident 1 had a physician order dated 8/1/2024, for Norco (a medication used to treat moderate to severe pain) Oral Tablet 5-325 milligram (MG, a unit of measurement), give one (1) tablet by mouth every four (4) hours as needed (PRN) for severe pain. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/2/2024 at 10:07 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Medication Administration Record (MAR), dated September 2024, was reviewed. The MAR indicated Resident 1 did not receive Norco PRN for severe pain on 9/25/2024. The MAR indicated Resident 1 received Norco PRN for severe pain on 9/26/2024 at 5 p.m. LVN 1 stated Resident 1 was able to notify the nursing staff when Resident 1 was experiencing pain. LVN 1 stated in the morning of 9/26/2024 (around 9:30 a.m.), Resident 1 requested to have Norco due to Resident 1 experiencing pain. LVN 1 stated LVN 1 was not able to give Resident 1 Norco because the facility had run out of Resident 1's supply of Norco. During an interview on 10/2/2024 at 11:52 a.m. with Resident 1, Resident 1 stated the facility did not have Norco available for Resident 1 for two to three days. Resident 1 stated the nurses (in general) kept saying the missing Norco was on its way from the pharmacy. Resident 1 stated the missing Norco made Resident 1 feel mad. During a telephone interview on 10/2/2024 at 11:54 a.m. with LVN 2, LVN 2 stated LVN 2 gave Resident 1 the last Norco from Resident 1's supply of Norco on 9/24/2024. LVN 2 stated someone (unidentified) had already asked the Pharmacy for a refill of Resident 1's Norco. LVN 2 stated Resident 1 asked LVN 2 for Norco on 9/25/2024. LVN 2 stated LVN 2 was not able to give Resident 1 his Norco since Resident 1's Norco supply ran out. During a telephone interview on 10/2/2024 at 12:58 p.m. with the facility's Pharmacist (PH), the PH stated the Pharmacy received a refill request from the facility for Resident 1's Norco on 9/22/2024. The PH stated the Pharmacy needed an authorization form from Resident 1's nurse practitioner before they could resupply Resident 1's Norco. The PH stated the Pharmacy emailed the authorization form to Resident 1's nurse practitioner on 9/24/2024. The PH stated the pharmacy did not receive the authorization form until 9/26/2024, and that the authorization form was still missing information. The PH stated Resident 1's new supply of Norco was delivered on 9/27/2024 at 5:04 a.m. (Resident 1's supply of Norco was empty for 2 days). During an interview on 10/2/2024 at 1:16 p.m. with the Director of Nursing (DON), the DON stated when a resident (in general) had an order for a medication then the medication needed to be available to give to the resident. During a review of the facility's policy and procedure (P&P) titled, Pain Management, undated, the P&P indicated, Effective pain control is an important part of a resident's treatment. The P&P indicated, Health professionals are to respond quickly to a resident's reports of pain. The P&P indicated, M.D. (physician) orders are to be made for pharmacological (relating to treatment that uses drugs) and non-pharmacological interventions as needed. To be considered are the following: .Around-the-clock medication dosing in order to maintain a therapeutic (helps to heal or restore health) drug level that reduces any recurrence of pain. In addition, PRN medications may be needed for breakthrough pain.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44027 Based on interview and record review, the facility failed to ensure the supply of pain medication for one of three sampled residents (Resident 1) was refilled/restocked timely (promptly/without delay) and readily available when Resident 1 needed the medication. This failure resulted in Resident 1 to feel mad and had the potential for Resident 1 to experience unrelieved pain. Cross Reference F697 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to facility on 6/25/2024 with diagnoses including respiratory failure (when the lungs cannot get enough oxygen into the blood), difficulty in walking, and dysphagia (difficulty swallowing foods or liquids). During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 7/1/2024, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). Resident 1 was dependent (helper does all the effort) on staff for toileting and bathing. The MDS indicated Resident 1 did not have pain in the last five days. During a review of Resident 1's untitled care plan (CP), initiated 8/5/2024, the CP indicated Resident 1 was at risk for pain and discomfort. The CP interventions included for staff to assess characteristics of pain: location, duration, quality, aggravating/alleviating factors, radiation, intensity, and notify the physician as needed and administer medication as ordered. During a review of Resident 1's Order Summary Report dated 9/26/2024, the Order Summary Report indicated Resident 1 had a physician order dated 8/1/2024, for Norco (a medication used to treat pain) Oral Tablet 5-325 milligram (MG, a unit of measurement), give one (1) tablet by mouth every four (4) hours as needed (PRN) for severe pain. During a concurrent interview and record review on 10/2/2024 at 10:07 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Medication Administration Record (MAR), dated September 2024, was reviewed. The MAR indicated Resident 1 did not receive Norco PRN for severe pain on 9/25/2024. The MAR indicated Resident 1 received Norco PRN for severe pain on 9/26/2024 at 5 p.m. LVN 1 stated Resident 1 was able to notify the nursing staff when Resident 1 was experiencing pain. LVN 1 stated in the morning of 9/26/2024 (around 9:30 a.m.), Resident 1 requested to have Norco due to Resident 1 experiencing pain. LVN 1 stated LVN 1 was not able to give Resident 1 Norco because the facility had run out of Resident 1's supply of Norco. LVN 1 stated the Registered Nurse (RN) supervisor, RN 1, was already aware Resident 1's supply of Norco was used up. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/2/2024 at 10:17 a.m. with RN 1, RN 1 stated LVN 1 informed RN 1 on 9/26/2024 that Resident 1's supply of Norco ran out. RN 1 stated when RN 1 contacted the facility's pharmacy (the Pharmacy), the Pharmacy informed RN 1 that Resident 1's new supply of Norco would arrive in the next medication delivery (9/25/2024). RN 1 stated Resident 1's supply of Norco did not arrive with the medication delivery because the Pharmacy was still missing an authorization form that needed to be filled out by Resident 1's physician or nurse practitioner. RN 1 stated the authorization forms had already been sent to the Pharmacy, but the forms were missing information from Resident 1's physician or nurse practitioner. During an interview on 10/2/2024 at 11:52 a.m. with Resident 1, Resident 1 stated the facility did not have Norco available for Resident 1 for two to three days. Resident 1 stated the nurses (in general) kept saying the missing Norco was on its way from the pharmacy. Resident 1 stated the missing Norco made Resident 1 feel mad. During a telephone interview on 10/2/2024 at 11:54 a.m. with LVN 2, LVN 2 stated LVN 2 gave Resident 1 the last Norco from Resident 1's supply of Norco on 9/24/2024. LVN 2 stated someone (unidentified) had already asked the Pharmacy for a refill of Resident 1's Norco. LVN 2 stated Resident 1 asked LVN 2 for Norco on 10/25/2024. LVN 2 stated LVN 2 was not able to give Resident 1 his Norco since Resident 1's Norco supply ran out. LVN 2 stated when LVN 2 called the Pharmacy on 9/25/2024, the Pharmacy informed LVN 2 the Pharmacy could not refill Resident 1's Norco because the Pharmacy had not received the authorization form from Resident 1's physician yet. During a telephone interview on 10/2/2024 at 12:41 p.m. with Pharmacy Technician (PT) 1, PT 1 stated facility staff needed to request refills of Norco three days before the resident's (in general) last dose of medication was used. PT 1 stated if Resident 1's last dose of Norco was given on 9/24/2024, then the facility should have requested the refill on 9/21/2024. PT 1 stated a refill of Norco could take up to three days to refill/supply because the resident's (in general) physician needed to provide authorization for the refill. During a telephone interview on 10/2/2024 at 12:58 p.m. with the facility's Pharmacist (PH), the PH stated the Pharmacy received a refill request for Resident 1's Norco on 9/22/2024. The PH stated the Pharmacy needed an authorization form from Resident 1's nurse practitioner before they could resupply Resident 1's Norco. The PH stated the Pharmacy emailed the authorization form to Resident 1's nurse practitioner on 9/24/2024. The PH stated the pharmacy did not receive the authorization form until 9/26/2024, and that the authorization form was still missing information. The PH stated Resident 1's new supply of Norco was delivered on 9/27/2024 at 5:04 a.m. (Resident 1's supply of Norco was empty for 2 days). During an interview on 10/2/2024 at 1:16 p.m. with the Director of Nursing (DON), the DON stated when a resident (in general) had an order for a medication then the medication needed to be available to give to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy, dated April 2008, the P&P indicated, Schedule II controlled medications (medications with a high potential for abuse, with use potentially leading to severe psychological or physical dependence) prescribed for a specific resident are delivered to the facility on ly if a written prescription has been received by the pharmacy prior to dispensing. In an emergency situation, the provider pharmacy can accept a telephone order. A follow-up written prescription is sent to the provider pharmacy by the prescriber. A facsimile order may be sent to the provider pharmacy if it is written by the prescriber.